

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1158 CERTIFICATE OF DEATH

Reg. Dist. No.

01151

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE				
Somerset Maryland		Maryland County Somerset				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Deal Island	Lifetime	Deal Island				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION AT HER HOME		d. STREET ADDRESS 1 Main Road				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First	Middle	Last			
ALMA			ABBOTT			
4. DATE OF DEATH	Month	Day	Year			
	JAN	25	1960			
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH			
FEMALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	MAR-19-1901			
9. AGE (In years less birthday) 58 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. DAYS	12. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?			
Household	Household Duties	MARYLAND	U.S.A.			
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME					
WILLIAM C. ABBOTT	VIRGINIA WEBSTER					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address			
No	NONE	MOLLIE WEBSTER	Deal Island			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						
Anemia Hypersplenism						
DUE TO						
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.						
Anemia						
DUE TO						
(b)						
(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 3-28-58, 19, to 1-25-60, 19, that I last saw the deceased alive on 1-25-60, 19, and that death occurred at 1:15 PM, from the causes and on the date stated above.						
ADDRESS (Street, city or town, state)						
DATE SIGNED						
ACTUAL SIGNATURE	Everett C. Sutter			M.D.	Dames Quarter, Maryland	1-26-60
PHYSICIAN'S NAME (Type)	Everett C. Sutter MD					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORI	22d. LOCATION (City, town, or county)			
Burial	JAN 27-1960	St. John's Cemetery	Deal Island MD			
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE			
Z. Webster Deal Island	108	FEB 1 '60	Arthur L. Trahan			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BY DROMIT LAB-HFABR 30 THE 73A0231

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1159 CERTIFICATE OF DEATH

01152

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
<u>SOMERSET</u>		<u>MARYLAND</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
<u>CHANCE</u>		<u>Lifetime</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
<u>AT HER HOME</u>		<u>MAIN ROAD</u>	
3. NAME OF DECEASED (Type or print)		First	Middle
<u>MAMIE</u>		<u>BECKETT</u>	<u>LOST</u>
4. DATE OF DEATH		Month	Day
		<u>JAN</u>	<u>14</u>
		Year	<u>1960</u>
5. SEX		6. COLOR OR RACE	
<u>Female</u>		<u>Negro</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>House hold</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House hold</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>PETER WHITE</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE JONES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>John Curtis</u>		Address <u>Chance Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>340.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		Meningitis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>generalized arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-13-60</u> , 19____, to <u>1-14-60</u> , 19____, that I last saw the deceased alive on <u>1-14-60</u> , 19____, and that death occurred at <u>6A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Dames Quarter, Maryland</u>		DATE SIGNED <u>1-16-60</u>	
ACTUAL SIGNATURE <u>Everett Sutter</u>		M.D.	
PHYSICIAN'S NAME (Type) <u>Everett C. Sutter MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>JAN 17-1960</u>	
22c. NAME OF CEMETERY OR CREMATORIUM <u>St. Charles Methodist Church</u>		22d. LOCATION (City, town, or county) <u>Chance Rd</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L.S. Webster</u>		ADDRESS <u>Dead Island</u>	
24a. REC'D BY REGISTRAR DATE <u>JAN 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF CALIFORNIA - DIVISION OF
CENSUS - CERTIFICATE OF DEATH

DEATH CERTIFICATE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01153

Reg. Dist. No.

1160

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY SOMERSET		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b 52 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 39 CRISFIELD		d. STREET ADDRESS MARINER'S ROAD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. MCCREADY MEMORIAL HOSP.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First HARLAN	Middle	Last BYRD	4. DATE OF DEATH Month JANUARY	Day 19	Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 5-29-1907	9. AGE (In years last birthday) 52 yrs.	10. IF UNDER 1 YEAR Months 52	Days 0	IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSURANCE LIFE INSURANCE AGENT		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN H. BYRD		14. MOTHER'S MAIDEN NAME SUSAN EVANS					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		INFORMANT EDNA BYRD, CRISFIELD, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, stomach DUE TO 151X INTERVAL BETWEEN ONSET AND DEATH 2 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1958 , to Jan 1960 , that I last saw the deceased alive on JAN. 19 1960 , and that death occurred at 1:40 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) MAIN STREET DATE SIGNED DATE SIGNED							
ACTUAL SIGNATURE C. G. Rawley		M.D.					
PHYSICIAN'S NAME (Type) C. G. RAWLEY, M.D.				CRISFIELD, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-22-1960		22c. NAME OF CEMETERY OR CREMATORIUM MARINER'S CEMETERY		22d. LOCATION (City, town, or county) CRISFIELD MD. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE L. S. Webster Crisfield Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 26 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1980 CENSUS OF TRADE

BUREAU OF THE CENSUS U.S. DEPARTMENT OF COMMERCE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01154

Reg. Dist. No.

1156

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY Somerset		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> d. STREET ADDRESS Beckford Ave., Ext'd.	
3. NAME OF DECEASED (Type or print)	First Charles	Middle William	Last Collins
4. DATE OF DEATH January 19, 1960	Month Day Year		
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 6, 1959
9. AGE (In years last birthday) 5 yrs.	IF UNDER 1 YEAR 5 Months	IF UNDER 24 HRS. 5 Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Princess Anne, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Gilbert H. Walston	14. MOTHER'S MAIDEN NAME Madeline Collins		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT Gilbert H. Walston - Princess Anne, Maryland	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia		INTERVAL BETWEEN ONSET AND DEATH 4 days	
491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>R. H. Johnson</i>	DATE SIGNED Jan. 19, 1960		
EXAMINER'S NAME (Type) R. H. Johnson, M.D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-20-60	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Hope	22d. LOCATION (City, town, or county) Princess Anne, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE <i>William J. Powers Jr. Funeral Director</i>	ADDRESS 4000 21st Street, Md.	24a. REC'D BY REGISTRAR JAN 21 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

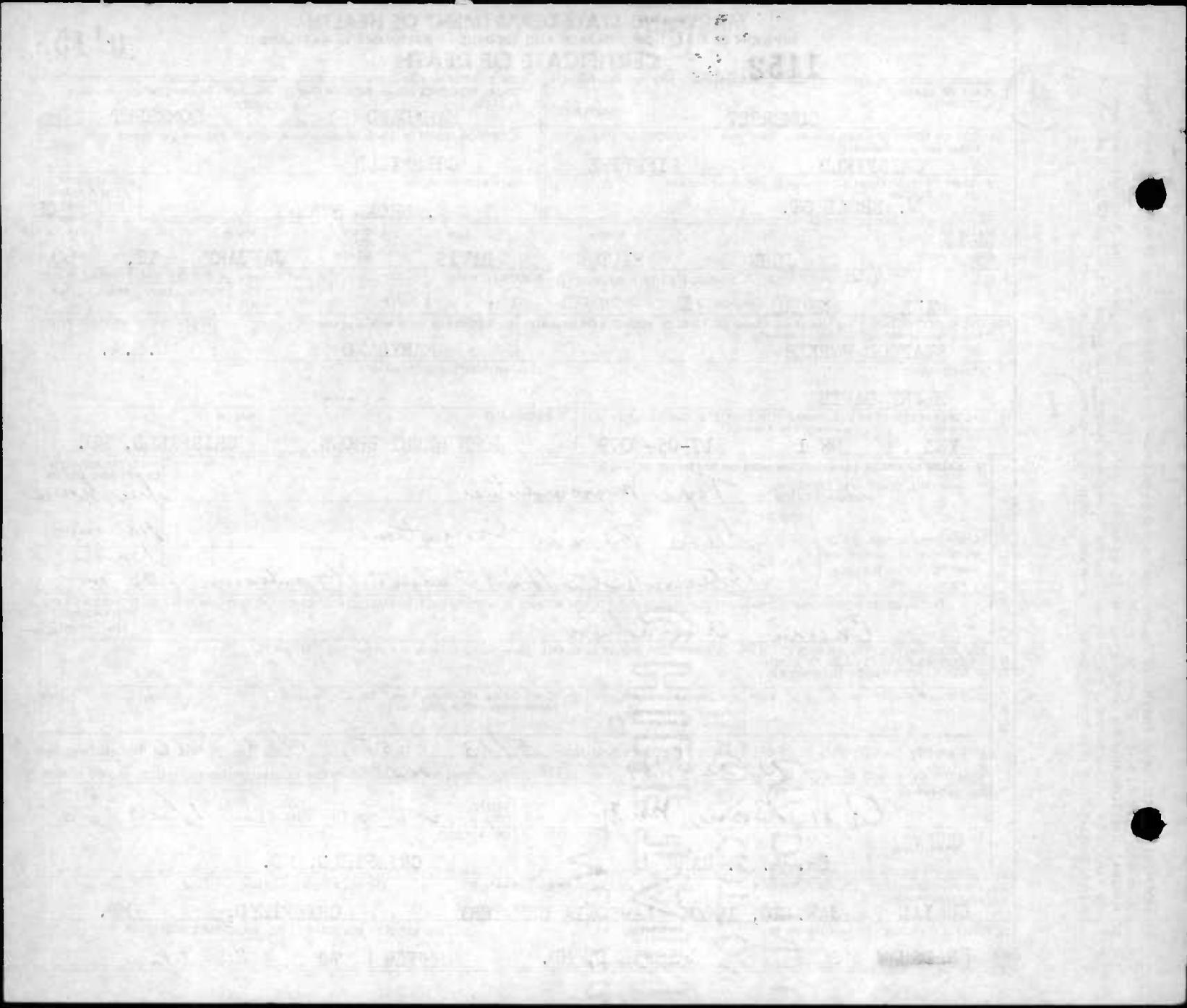
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01155

1152 Items 8, 9, Film 2525-5-60 et

CERTIFICATE OF DEATH

PLACE OF DEATH a. COUNTY SOMERSET		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b LIFETIME		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 39 CRISFIELD		d. STREET ADDRESS W. BROAD STREET	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION W. BROAD ST.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOHN		First MILTON Middle DAVIS		4. DATE OF DEATH JANUARY 18, 1960		Month Day Year	
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 1, 1896	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAFOOD WORKER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY DAVIS				14. MOTHER'S MAIDEN NAME ---			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] YES		16. SOCIAL SECURITY NO. WW 1 217-05-8099		17. INFORMANT JOHN HENRY BROWN		Address CRISFIELD, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Topic Myocarditis</i> DUE TO <i>420.0</i> INTERVAL BETWEEN ONSET AND DEATH <i>few hours</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Severe Passive Congestion</i> 18 mo (c) <i>Arteriosclerotic Heart Disease - Hypertension</i> Known DUE TO <i>Chronic Alcoholism</i> 30 mo							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/13 1957 to 1/18 1960 that (I) (we) lost saw the deceased alive on 12/22 1959 , and that death occurred over 6 months, from the causes and on the date stated above.							
22a. SIGNATURE <i>A. N. Barr, M.D.</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/25/60			
22c. PHYSICIAN'S NAME (Type) DR. A. N. BARR		22d. ADDRESS CRISFIELD, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN. 20, 1960		23c. NAME OF CEMETERY OR CREMATORIUM LAWSONIA CEMETERY		23d. LOCATION (City, town, or county) (State) CRISFIELD, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE BRADSHAW & SONS		ADDRESS CRISFIELD, MD.		25a. REC'D BY REGISTRAR FEB 1 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Evans	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01156

1. PLACE OF DEATH a. COUNTY		1161 SOMERSET MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Rural Marion All his life		b. COUNTY		SOMERSET		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 171				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Marion				
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				d. STREET ADDRESS Box 171				
3. NAME OF DECEASED (Type or print)		First Edward	Middle Dennis	Last Dennis	4. DATE OF DEATH 1-26-1960	Month 1	Day 26	Year 1960
5. SEX M		6. COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-16-1887		9. AGE (In years lost birthday) 73 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME P Dennis		14. MOTHER'S MAIDEN NAME Julia ?						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 184-09-7956		17. INFORMANT Mrs. Beulah Dennis - Marion, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. } (b) Chronic Myocarditis - C. Int. Nephritis DUE TO (c)		Acute Dil. of Heart, Uremia				INTERVAL BETWEEN ONSET AND DEATH 2 weeks about 4 years.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Nov. 9, 1959, to Jan. 26, 1960, that I last saw the deceased alive on Jan. 26, 1960, and that death occurred at 2:30 PM, from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED 1-29-60		
ACTUAL SIGNATURE George C. Coulbourn		M.D.		Marion Station, Maryland				
PHYSICIAN'S NAME (Type) George C. Coulbourn, M.D.				Marion Station, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-31-60		22c. NAME OF CEMETERY OR CREMATORIUM Family Cem		22d. LOCATION (City, town, or county) Marion, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Incenton B. Selley, Salisbury, Md.		ADDRESS		24a. REC'D BY REGISTRAR Date FEB 2 '60		24b. REGISTRAR'S SIGNATURE C. S. Evans		

CERTIFICATE OF SERVICE

MAY 2000

Case No.

1997-4

Service made on [REDACTED] at [REDACTED] on [REDACTED] by [REDACTED]

Service made on [REDACTED] at [REDACTED] on [REDACTED] by [REDACTED]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1157 CERTIFICATE OF DEATH

Reg. Dist. No.

01157

1. PLACE OF DEATH o. COUNTY		Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Beechwood St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Herbert	Middle R.	Last Dryden	4. DATE OF DEATH	Month January	Day 30	Year 1960
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 14, 1882	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) railroad		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Rufus Dryden				14. MOTHER'S MAIDEN NAME Ida Long			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Hollis Dryden, Pocomoke City, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis (c) Renility							
INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 10 yrs. 10 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Secondary Anemia							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1958, to Jan. 30, 1960, that I last saw the deceased alive on Jan. 30, 1960, and that death occurred at Princess Anne, Md., from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>A.C. Lewis</i>		M.D.		ADDRESS (Street, city or town, state) Princess Anne, Md.		DATE SIGNED 1/30/60	
PHYSICIAN'S NAME (Type) A.C. Lewis, M.D.		Princess Anne, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2/1/60		22c. NAME OF CEMETERY OR CREMATORIUM Immanuel		22d. LOCATION (City, town, or county) (State) Princess Anne, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James Skinner</i>				ADDRESS Princess Anne, Md.		24a. REC'D BY REGISTRAR FEB 5 '60	
						24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1162 CERTIFICATE OF DEATH

Reg. Dist. No.

01158

1. PLACE OF DEATH a. COUNTY Somerset		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Princess Anne		c. LENGTH OF STAY IN lb life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Princess Anne	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)	First Sidney	Middle B.	Last Ennis
4. DATE OF DEATH	Month January	Day 31	Year 1960
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 1887
9. AGE (In years last birthday) 72 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Reited farmer	11. KIND OF BUSINESS OR INDUSTRY Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Sidney C. Ennis	14. MOTHER'S MAIDEN NAME Rose Matthews		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	INFORMANT Harvey Ennis	Address Princess Anne, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Coronary arteriosclerosis years			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) uremia			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11-30-59 , 19____, to 1-31-60 , 19____, that I last saw the deceased alive on 1-31-60 , 19____, and that death occurred at 6a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Everett Sutter</i>		ADDRESS (Street, city or town, state) Dames Quarter, Maryland	
PHYSICIAN'S NAME (Type) Everett C. Sutter MD		DATE SIGNED 2/1/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 2/2/60	22c. NAME OF CEMETERY OR CREMATORIUM Baptist Cemetery	22d. LOCATION (City, town, or county) Pocomoke City, Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>James Neuman</i>	ADDRESS Princess Anne, Md.	24a. REC'D BY REGISTRAR FEB 5 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01159

1163 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY SOMERSET		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND		b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRI\$FIELD		c. LENGTH OF STAY IN 1b 8 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 39 CRI\$FIELD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. McCREADY MEMO. HOSP.		d. STREET ADDRESS SOMERSET AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First GORDON	Middle Carroll	Last EVANS	4. DATE OF DEATH JANUARY	Month JANUARY	Day 3	Year 1960
5. SEX MALE	6. COLOR OR RACE WHTTE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 6-8-93	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	IF UNDER 24 HRS. Minutes 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STORE OWNER		10b. KIND OF BUSINESS OR INDUSTRY CONFETIONERY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIE A. EVANS		14. MOTHER'S MAIDEN NAME Elpertena Tyler					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. WW 1	INFORMANT KENNETH EVANS		Address CRISFIELD, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Infarction DUE TO 420.1							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Coronary Thrombosis DUE TO (c) Hypertension, on + Atherosclerosis							
INTERVAL BETWEEN ONSET AND DEATH 1 week							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 22, 1959 , to Jan. 3, 1960 , and that I last saw the deceased alive on JAN. 3, 1960 , and that death occurred at 2:35 PM from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) CRISFIELD, MD.							
DATE SIGNED D. M. Peyton							
ACTUAL SIGNATURE SARAH M. PEYTON, M.D.							
PHYSICIAN'S NAME (Type) SARAH M. PEYTON, M.D. CRISFIELD, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-6-60	22c. NAME OF CEMETERY OR CREMATORIUM Sunnyridge Cemetery		22d. LOCATION (City, town, or county) Crisfield, Maryland (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Maryland				24a. REC'D BY REGISTRAR JAN 6, 1960		24b. REGISTRAR'S SIGNATURE Arthur S. Kinne	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

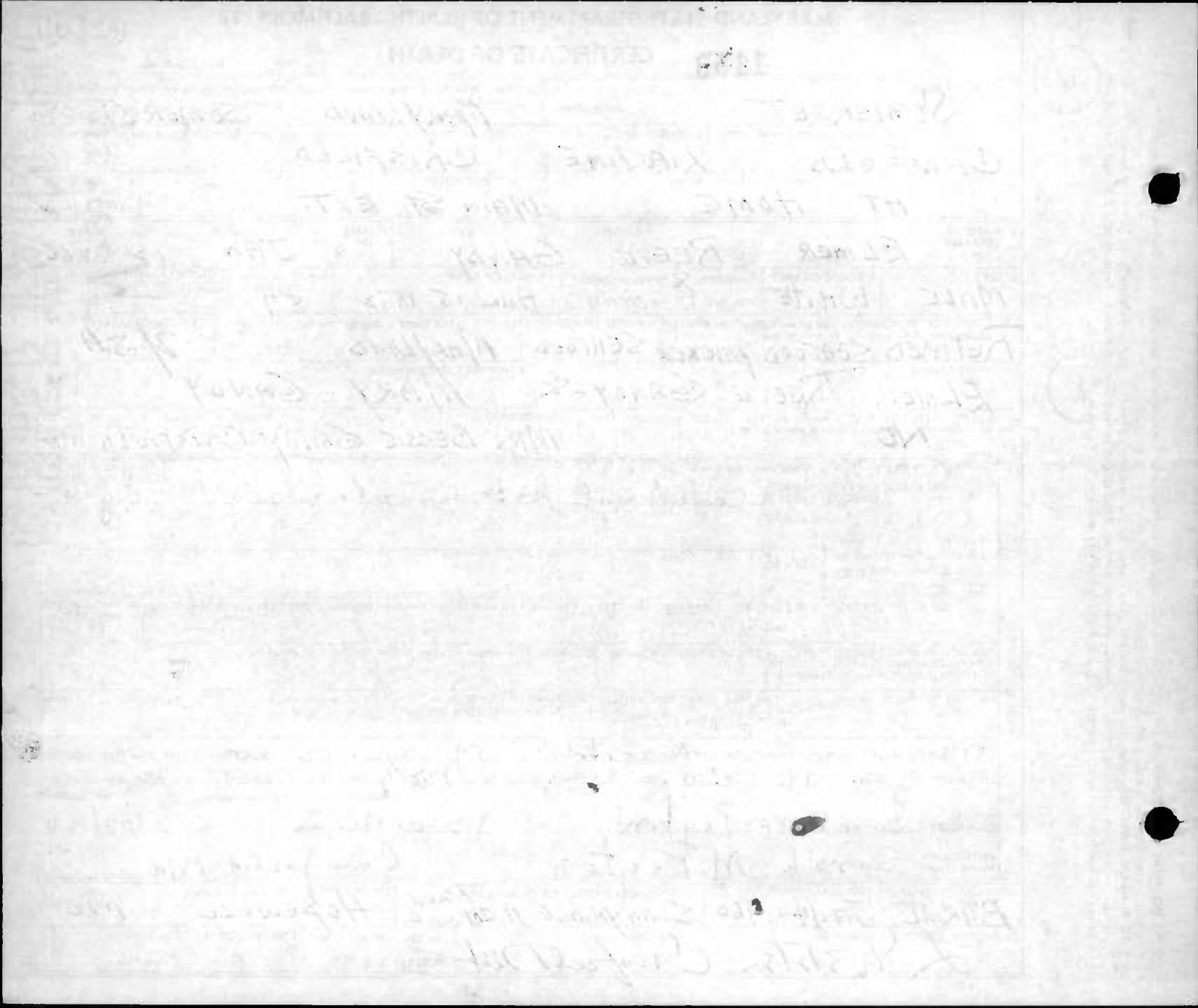
01160

1153

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>SOMERSET</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CRISFIELD</i>		c. LENGTH OF STAY IN 1b <i>LIFETIME</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>AT HOME</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>ELMER</i>	Middle <i>REEVE</i>	Last <i>GANDY</i>
4. DATE OF DEATH	Month <i>JAN</i>	Day <i>12</i>	Year <i>1960</i>
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>AUG-15-1872</i>
9. AGE (In years lost birthday) <i>87 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETired SEAFOOD PACKER SEAFOOD</i>	11. KIND OF BUSINESS OR INDUSTRY <i>SEAFOOD</i>	12. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>
13. FATHER'S NAME <i>ELMER REEVE GANDY SR</i>	14. MOTHER'S MAIDEN NAME <i>MARY GANDY</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>	
16. SOCIAL SECURITY NO.	INFORMANT <i>MRS BESSIE GANDY-CRISFIELD MD</i>	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Atherosclerosis</i> DUE TO <i>334X</i>			
Conditions, if any, which goe rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>October 1959</i> to <i>January 2, 1960</i> that I last saw the deceased alive on <i>Dec 11, 1960</i> , and that death occurred at <i>12pm</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Sarah M. Peyton</i>		ADDRESS (Street, city or town, state) <i>334 Main St., Crisfield MD</i>	
PHYSICIAN'S NAME (Type) <i>Sarah M. Peyton</i>		DATE SIGNED <i>1/19/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL JAN 14-1960</i>		22b. DATE THEREOF <i>JAN 14-1960</i>	22c. NAME OF CEMETERY OR CREMATORIAL PARK <i>SUNNYRIDGE Memorial Park</i>
22d. LOCATION (City, town, or county) <i>HOPEDALE MD</i>		23. FUNERAL DIRECTOR'S SIGNATURE <i>L. Webster Crisfield MD</i>	
24a. REC'D BY REGISTRAR <i>JAN 18 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Carlene & Kima</i>	

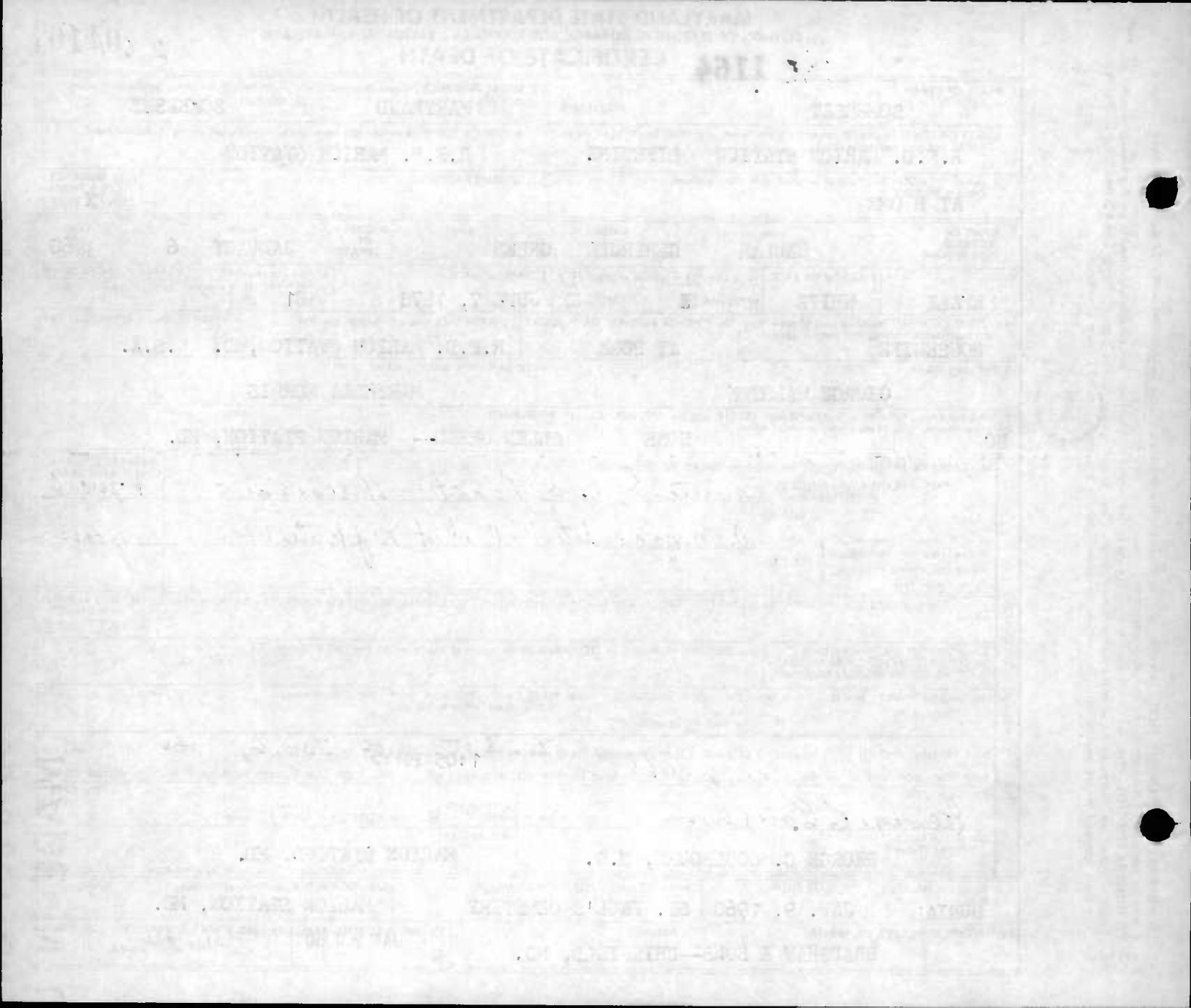


TO HOSPITAL may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 1164 CERTIFICATE OF DEATH

20A161

1. PLACE OF DEATH a. COUNTY SOMERSET		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F.D. MARION STATION		c. LENGTH OF STAY IN 1b LIFETIME		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY SOMERSET	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION AT HOME						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F.D. MARION STATION			
3. NAME OF DECEASED (Type or print) BEULAH		First GERTRUDE	Middle GREEN	Last 	4. DATE OF DEATH JANUARY 6 1960	Month JANUARY	Day 6	Year 1960	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH JUNE 7, 1878	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS. Days 	Hours 	Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) R.F.D. MARION STATION, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME GEORGE WALSTON				14. MOTHER'S MAIDEN NAME MARZELLA MORRIS					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT ALLEN GREEN-- MARION STATION, MD.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									INTERVAL BETWEEN ONSET AND DEATH 1 week
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute dil. of heart - I septic - DUE TO 422.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) C. myocarditis - C. diff. Nephritis DUE TO (c) years -									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Xia 25 1960 to Jan. 6, 1960		(County) 	(State)
21. I certify that (I) (this hospital) attended the deceased from 1:05 PM to Jan. 6, 1960 , that (I) (we) last saw the deceased alive on Jan. 6, 1960 , and that death occurred at M , from the causes and on the date stated above.									
22a. SIGNATURE George C. Coulbourn		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 			
22c. PHYSICIAN'S NAME (Type) GEORGE C. COULBOURN, M.D.		22d. ADDRESS MARION STATION, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN. 9, 1960		23c. NAME OF CEMETERY OR CREMATORIUM ST. PAUL'S CEMETERY		23d. LOCATION (City, town, or county) MARION STATION, MD.			(State)
24. FUNERAL DIRECTOR'S SIGNATURE BRADSHAW & SONS--CRISFIELD, MD.		ADDRESS		25a. REC'D. BY REGISTRAR JAN 20 60		25b. REGISTRAR'S SIGNATURE Arthur S. Traas			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01162

Reg. Dist. No.

1165

1. PLACE OF DEATH a. COUNTY Somerset			MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manokin			c. LENGTH OF STAY IN lb 60 years			b. COUNTY Somerset		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			X Manokin			d. STREET ADDRESS		
						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

3. NAME OF DECEASED (Type or print)	First Martha	Middle Jones	Last Jones	4. DATE OF DEATH January 13, 1960	Month January	Day 13	Year 1960
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5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 12/4/1880	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Housework	11. BIRTHPLACE (State or foreign country) Blackstone, Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME unknown	14. MOTHER'S MAIDEN NAME unknown
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Irene Ayers - Manokin, Maryland	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			INTERVAL BETWEEN ONSET AND DEATH minutes
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1 Acute Coronary Heart Disease			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
(b) Arteriosclerosis and Ch. Myocarditis			years
DUE TO (c)			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town), (County), (State)
19			

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL SIGNATURE <i>R. H. Johnson</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 1/14/60
EXAMINER'S NAME (Type) R. H. Johnson, M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/17/60	22c. NAME OF CEMETERY OR CREMATORIUM St. Paul	22d. LOCATION (City, town, or county) Revelles Neck)-Westover, Maryland	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wellman & Son Funeral Home</i>	ADDRESS 1000 W. Pratt Street	24a. REC'D BY REGISTRAR JAN 15 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	DATE

THE HIGH COURT OF VICTORIA CELEBRATE THE DEATH OF QUEEN VICTORIA.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01163

1166 CERTIFICATE OF DEATH

Reg. Dist. No. 261-

1. PLACE OF DEATH o. COUNTY Somerset	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY Somerset
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westover	c. LENGTH OF STAY IN 1b 4 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Princess Annr
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS	

3. NAME OF DECEASED (Type or print)	First Georgia	Middle Kohlheim	Last	4. DATE OF DEATH Jan., 1, 1960	Month	Day	Year
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 23, 1889	9. AGE (in years from birthday) yrs. 70	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.
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13. FATHER'S NAME James W. Butler	14. MOTHER'S MAIDEN NAME Cora Townsend
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 592X	16. SOCIAL SECURITY NO.	INFORMANT Mrs. Choley Ennis R.F.D. Westover, Md.	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Dil. of heart. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Chronic Art. Nephritis C. myositis	3 days from history years.
(b) 592X DUE TO	
(c) from history years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Sclerosis of Liver, General Arteriosclerosis -	

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Dec. 30, 1959, to Jan. 1, 1960, that I last saw the deceased alive on Jan. 1, 1960, and that death occurred at 7:30 A.M. from the causes and on the date stated above.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Venton	(County) Maryland	(State) Maryland
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21. I certify that I attended the deceased from Dec. 30, 1959, to Jan. 1, 1960 , that I last saw the deceased alive on Jan. 1, 1960 , and that death occurred at 7:30 A.M. from the causes and on the date stated above.	ADDRESS (Street, city or town, state) Marion Station	DATE SIGNED George C. Coulburn M.D.
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ACTUAL SIGNATURE George C. Coulburn	PHYSICIAN'S NAME (Type) George C. COULBOURN	MARION STATION, MARYLAND
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22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/4/59	22c. NAME OF CEMETERY OR CREMATORIUM Monie	22d. LOCATION (City, town, or county) Venton, Maryland
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23. FUNERAL DIRECTOR'S SIGNATURE James Henmon	ADDRESS Princess Anne, Md.	24a. REC'D BY REGISTRAR DATE JAN 12 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Mann
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HANOI PLANTATION

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BUDGET

INVESTMENT

BUDGET

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01164

1167

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE		
<i>Somerset</i>		MARYLAND <i>Md.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
<i>Rural Crisfield</i>	<i>life</i>	<i>Rural Crisfield X</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS			
<i>Asbury Are</i>	<i>Asbury Are</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>Hattie</i>	Middle <i>A</i>	Last <i>Lawson</i>	4. DATE OF DEATH Month <i>January</i> Day <i>13</i> Year <i>1960</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 14 1882</i>	9. AGE (In years last birthday) yrs. <i>77</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Md.</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>
13. FATHER'S NAME <i>Thomas Daugherty</i>		14. MOTHER'S MAIDEN NAME <i>Mary Moore</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		INFORMANT <i>Mrs. Maxwell Tyler Crisfield Md.</i> Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				
<i>420.1</i> DUE TO <i>Coronary Thrombosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Angina Pectoris</i> years -				
(c) <i>Arterio-sclerotic myocardial disease</i> years ,				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>April</i> , 19 <i>47</i> , to <i>Jan 12</i> , 19 <i>60</i> that I last saw the deceased alive on <i>Jan 9</i> , 19 <i>60</i> , and that death occurred at <i>Crisfield</i> M., from the causes and on the date stated above.				
ADDRESS (Street, city or town, state) <i>Crisfield Md.</i> DATE SIGNED				
ACTUAL SIGNATURE <i>O. Rawley</i>				
PHYSICIAN'S NAME (Type) <i>O. Rawley</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1/15/60</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Sunnyridge</i>	22d. LOCATION (City, town, or county) <i>Hopewell</i> (State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James Denmon Crisfield Md.</i>		ADDRESS	24a. REC'D BY REGISTRAR DATE <i>JAN 18 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5-152

AT&T BELL LABORATORIES
RESEARCH & DEVELOPMENT CENTER

AT&T BELL LABORATORIES

TO HOSPITAL (check if attending physician may be retained by the hospital or attending physician).

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

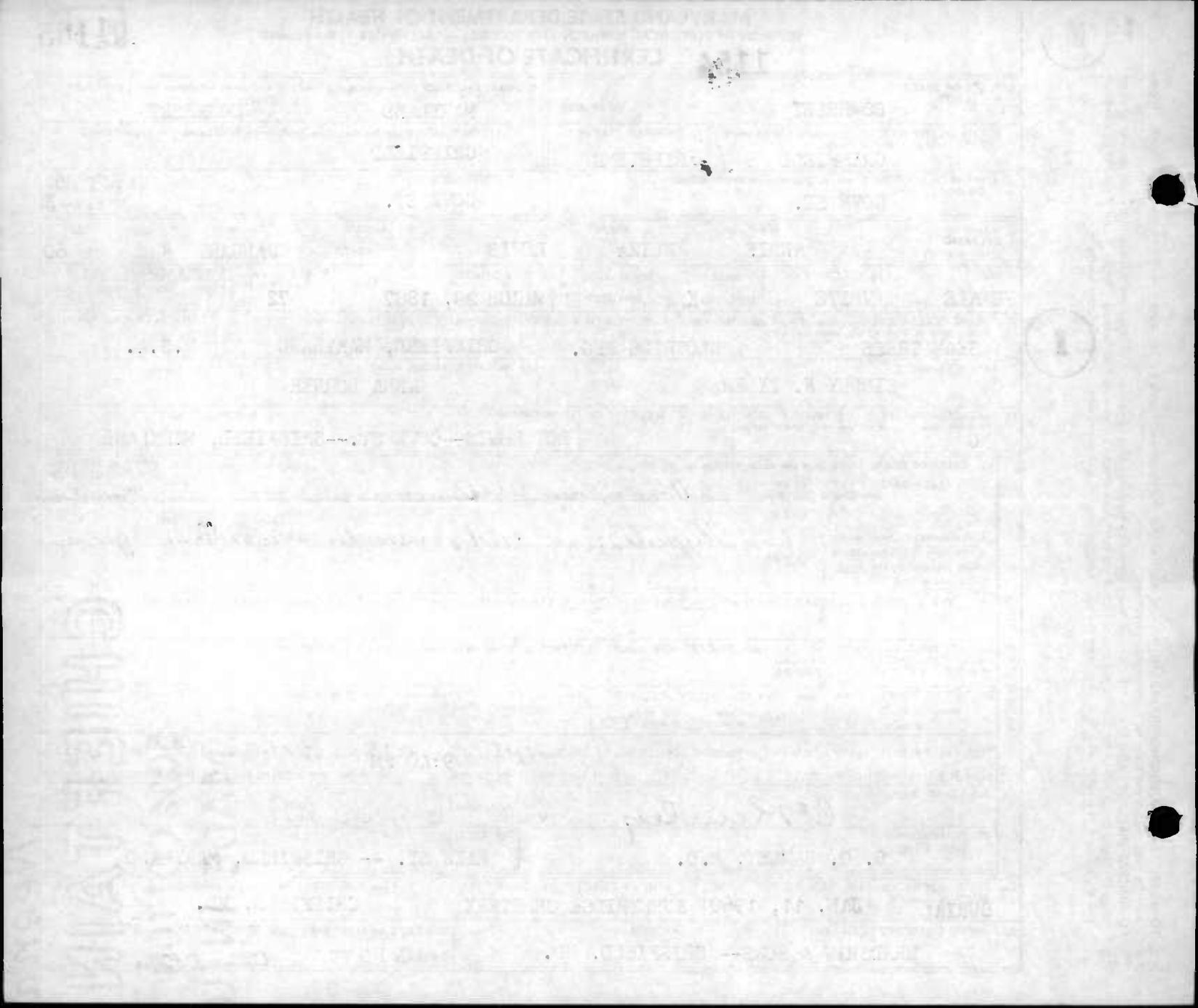
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1154

CERTIFICATE OF DEATH

01165

1. PLACE OF DEATH a. COUNTY SOMERSET		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b LIFETIME	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION COVE ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ANNIE		First ELIZA	Middle LEWIS
4. DATE OF DEATH JANUARY 8 1960	Month Day Year		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH MARCH 29, 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS		10b. KIND OF BUSINESS OR INDUSTRY CLOTHING MFG.	11. BIRTHPLACE (State or foreign country) CRISFIELD, MARYLAND
13. FATHER'S NAME SIDNEY K. TYLER		14. MOTHER'S MAIDEN NAME ANNA HORNER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	17. INFORMANT ROY LEWIS—COVE ST.—CRISFIELD, MARYLAND
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH minutes			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO Hypertensive cardio-nasal arteriosclerosis years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month Day Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept 9 1947 to Feb 19 1957 , that (I) (we) last saw the deceased alive on 2 19 , and that death occurred at M. from the causes and on the date stated above.			
22a. SIGNATURE C. G. Rawley		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) C. G. RAWLEY, M.D.		22d. ADDRESS MAIN ST. — CRISFIELD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF JAN. 11, 1960	23c. NAME OF CEMETERY OR CREMATORIUM SUNNYRIDGE CEMETERY	23d. LOCATION (City, town, or county) (State) CRISFIELD, MD.
24. FUNERAL DIRECTOR'S SIGNATURE BRADSHAW & SONS— CRISFIELD, MD.		ADDRESS	25a. REC'D BY REGISTRAR JAN 15 '60
			25b. REGISTRAR'S SIGNATURE Arthur S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01168

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		1168 Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Princess Anne		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Princess Anne	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First George J.	Middle Riggin	Last Riggin	4. DATE OF DEATH Month January Day 5 Year 1960
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 2, 1886	9. AGE (In years at birthday) 73 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Edward T. Riggin		14. MOTHER'S MAIDEN NAME Grace Ruark		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		INFORMANT Address Mrs. Mary Riggin RFD. Princess Anne	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchitis Pneumonia INTERVAL BETWEEN ONSET AND DEATH 1 week 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Tue 4 , 19 60 , to Jan 5 , 19 60 , that I last saw the deceased alive on Tue 4 , 19 60 , and that death occurred at 1009 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Princess Anne, Md. DATE SIGNED Eldon G. Marksman					
ACTUAL SIGNATURE Eldon G. Marksman M.D. PHYSICIAN'S NAME (Type) Eldon Marksman					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/8/60		22c. NAME OF CEMETERY OR CREMATORIUM Perryhawkin	
22d. LOCATION (City, town, or county) R.F.D. Princess Anne, Md.				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE James Herman		ADDRESS Princess Anne, Md.		24a. REC'D BY REGISTRAR JAN 12 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thorne	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1169

CERTIFICATE OF DEATH

Reg. Dist. No.

01167

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY SOMERSET		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b 18 MO.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. McCREADY MEMORIAL HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ARTHUR	Middle JAMES	Last TYLER
4. DATE OF DEATH	Month JANUARY	Day 15	Year 1960
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-18-1958
9. AGE (In years lost birthday) yrs. 1	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. KIND OF BUSINESS OR INDUSTRY	12. BIRTHPLACE (State or foreign country) MARYLAND
13. CITIZEN OF WHAT COUNTRY? U.S.A.	14. MOTHER'S MAIDEN NAME HAZEL MARSHALL		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	INFORMANT HAZEL TYLER, CRISFIELD, MARYLAND	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] 096.9 PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Vascular insufficiency of Ductus Arteriosus</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (b). (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 3 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan. 12, 1960 to Jan. 15, 1960 that I last saw the deceased alive on Jan. 15, 1960 , and that death occurred at 12:10 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Sarah M. Peyton</i>	M.D.	ADDRESS (Street, city or town, state) CRISFIELD, MARYLAND	
DATE SIGNED			
PHYSICIAN'S NAME (Type) SARAH M. PEYTON, M.D.,	CRISFIELD, MARYLAND		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 17, 1960	22c. NAME OF CEMETERY OR CREMATORIAL Private Cemetery	22d. LOCATION (City, town, or county) Crisfield, (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bradshaw & Sons - - - Crisfield, Md.</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE JAN 20 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Lyons</i>

CERTIFICATE OF DEATH

1902

DEATH CERTIFICATE

CERTIFICATE OF DEATH

DEATH CERTIFICATE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

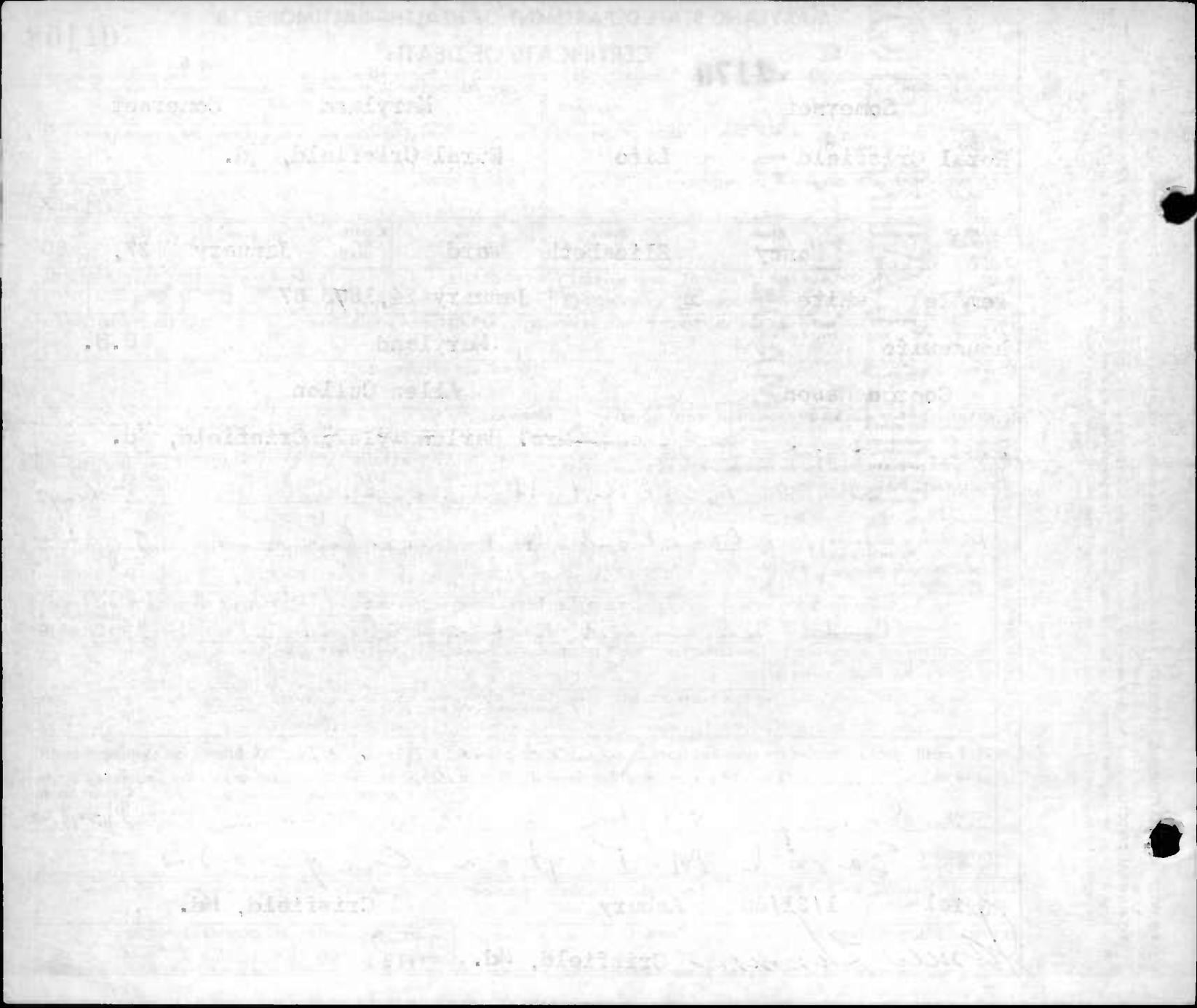
Reg. Dist. No.

01168

1. PLACE OF DEATH a. COUNTY		Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE		Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Crisfield		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Crisfield, d.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Nancy	Middle Elizabeth	Last Ward	4. DATE OF DEATH	Month January	Day 27, Year 1960
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years on birthday) January 24, 1893 87 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Mason				14. MOTHER'S MAIDEN NAME Allen Cullen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT		Address	
				Mrs. Harlan Tyler, Crisfield, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331 X		Cerebral Hemorrhage 5 days					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO		Cerebral Arteriosclerosis 5 years - (c) DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Generalized Arteriosclerosis					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____ to _____, and that I last saw the deceased alive on _____, and that death occurred at _____ M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)					
ACTUAL SIGNATURE Sarah M. Peyton M.D. 33 W. Main 1/29/60		DATE SIGNED					
PHYSICIAN'S NAME (Type) Sarah M. Peyton Crisfield, Md.							
22a. BURIAL, CREMATION, REVENGE (Specify) Burial		22b. DATE THEREOF 1/31/60		22c. NAME OF CEMETERY OR CREMATORIUM Asbury		22d. LOCATION (City, town, or county) Crisfield, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Arnold Denmon		ADDRESS Crisfield, Md.		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	
				DATE FEB 5 '60			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01169

1155

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH o. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Somerset		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION E. Chesapeake Ave.				d. STREET ADDRESS E. Chesapeake Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First LUCY	Middle JANE	Last WILSON	4. DATE OF DEATH January 29, 1960	Month January	Day 29	Year 1960	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Jan. 21, 1873	9. AGE (In years last birthday) yrs. 87	IF UNDER 1 YEAR Months 87	IF UNDER 24 HRS Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Crisfield, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James Purnell Lawson			14. MOTHER'S MAIDEN NAME Melissa ?					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-05-8539		17. INFORMANT Mrs. Emma Ennis, Crisfield, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive arteriosclerotic DUE TO (c) cardiovascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Hyper trophic arthritis						INTERVAL BETWEEN ONSET AND DEATH 12 mo.		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (1) (this hospital) attended the deceased from Jan. 8, 1960 to Jan. 29, 1960 , that (1) (we) last saw the deceased alive on Jan. 29, 1960 , and that death occurred at 4:45PM , from the causes and on the date stated above.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
22a. SIGNATURE R. W. Ireland		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2 Feb 60				
22c. PHYSICIAN'S NAME (Type) R. W. Ireland, M. D.		22d. ADDRESS Crisfield, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 31, 1960		23c. NAME OF CEMETERY OR CREMATORIUM Mariners Cemetery		23d. LOCATION (City, town, or county) (State) Crisfield, Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Maryland				ADDRESS		25a. REC'D. BY REGISTRAR DATE FEB 3 '60		
						25b. REGISTRAR'S SIGNATURE Arthur L. Krause		

